



# Provider Web Portal Quick Guide – Submitting a Claim with Other Insurance or Medicare Crossover Information

This Quick Guide covers when and how to enter other insurance information (Third-Party Liability) or Medicare crossover information.

Other insurance information should be entered on claims with Third-Party Liability (TPL)/commercial insurance. For claims billed to Medicare, provide the Medicare crossover information (see description below).

Medicare crossover information should be entered on any claim that was billed to Medicare first. The term “Crossover claim” may refer to a claim that is directly from Medicare (and has since “crossed over” to Health First Colorado [Colorado’s Medicaid Program] for processing) **or** a provider-initiated claim (submitted via the Provider Web Portal, batch or paper).” A crossover claim does not necessarily have to come directly from Medicare. Medicare Health Maintenance Organization (HMO) Co-pays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Co-pay amount into the Co-insurance Amount field under the Medicare Crossover Details section of the claim.

From the list below, identify the example below which most closely matches your claim, then proceed to the appropriate page for instructions. The sample screens shown in this guide may vary depending on claim information.

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# Entering Other Insurance Information on a Claim

## Professional Claim with TPL

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields, then check the "Include Other Insurance" box under the Claim Information section. Click "Continue." If you are submitting a claim with Medicare crossover information, see the instructions starting on page 13 of this guide.

**Submit Professional Claim: Step 1** ?

\* Indicates a required field.

Claim Type

---

**Provider Information**

Billing Provider ID   ID Type  Name

Taxonomy

Referring Provider ID   ID Type  Name

Taxonomy

Supervising Provider ID   ID Type  Name

Taxonomy

Service Facility Location ID   ID Type  Name

Taxonomy

---

**Member Information**

\*Member ID

Last Name  First Name

Birth Date

Address

City

State  Zip Code

---

**Claim Information**

Date Type  Date of Current

Accident Related Reason

\*Patient Number

\*Transport Certification  Yes  No

Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.

Previous Claim ICN

Note

\*Does the provider have a signature on file?  Yes  No

**Include Other Insurance**

Total Charged Amount \$0.00



**1. Enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select Other Carrier and type the Carrier Name.**

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
---	---------	-----------	--------

Click to collapse.

**Select an existing Carrier or specify an Other Carrier**

Existing Carrier

Other Carrier

\*Policy Holder Last Name

\*Policy ID

\*Effective From

Insurance Type

\*Responsibility

\*Claim Filing Indicator

\*First Name  MI

Effective To

Relationship to Insured

**Back to Step 1** **Continue** **Cancel**

### 3. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates (as applicable). Leave the Insurance Type field blank.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
---	---------	-----------	--------

Click to collapse.

Select an existing Carrier or specify an Other Carrier

Existing Carrier

Other Carrier

\*Policy Holder Last Name  \*First Name  MI

\*Policy ID

\*Effective From  Effective To

Insurance Type

\*Responsibility  \*Patient Relationship to Insured

**Leave the Insurance Type field blank.**

### 4. Select the payer responsibility from the drop-down list.

**Note:** Health First Colorado is the payor of last resort.

#### Other Insurance Details

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

[Refresh Other Insurance](#)

#	Carrier	Policy ID	Action
---	---------	-----------	--------

Click to collapse.

**Select an existing Carrier or specify an Other Carrier**

Existing Carrier

Other Carrier

\*Policy Holder Last Name  \*First Name  MI

\*Policy ID

\*Effective From  Effective To

Insurance Type

\*Responsibility  \*Patient Relationship to Insured

\*Claim Filing Indicator

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- P-Primary
- S-Secondary
- T-Tertiary
- U-Unknown
- A-Payer Responsibility Four
- B-Payer Responsibility Five
- C-Payer Responsibility Six
- D-Payer Responsibility Seven
- E-Payer Responsibility Eight
- F-Payer Responsibility Nine
- G-Payer Responsibility Ten
- H-Payer Responsibility Eleven

### 5. Select the relationship of the covered individual to the responsible individual from the drop-down list.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

[Refresh Other Insurance](#)

#	Carrier	Policy ID	Action
---	---------	-----------	--------

Click to collapse.

Select an existing Carrier or specify an Other Carrier

Existing Carrier

Other Carrier

\*Policy Holder Last Name  \*First Name  MI

\*Policy ID

\*Effective From  Effective To

Insurance Type

\*Responsibility

\*Patient Relationship to Insured

- 01-Spouse
- 18-Self
- 19-Child
- 20-Employee
- 21-Unknown
- 39-Organ Donor
- 40-Cadaver Donor
- 53-Life Partner
- G8-Other Relationship

\*Claim Filing Indicator

[Back to Step 1](#)  [Go to Top](#)



**8. Proceed to the Submit Professional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added.**

**Whether the TPL was paid or denied, you must enter a paid date.**

## TPL Denied

**If the TPL was denied, enter "0.00" in the Paid Amount field and "1" in the Paid Units field.**

**Once complete, click "Submit."**

**Submit Professional Claim: Step 3**

\* Indicates a required field.

Claim Type Professional

**Provider Information**

Billing Provider ID 1234567891 ID Type NPI Name Medical Provider

Taxonomy Clinic/Center - Primary Care

**Patient and Claim Information**

Member ID Z123456 Member Jane Smith Gender Female Birth Date mm/dd/ccyy Total Charged Amount \$0.00

**Diagnosis Codes**

**Other Insurance Details**

#	Carrier	Policy ID
1	000749-HUMANA HEALTH CARE	5325234

**Service Details**

Select the row number to edit the row. Click the Remove link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

**Other Insurance for Service Detail**

Click the row number to edit the row. Click the Remove link to remove the entire row.

#	Carrier	Paid Amount	Paid Date	Paid Units	Action
1					

Click to collapse.

Other Carrier

\*Paid Amount \*Paid Date \*Paid Units

Add Cancel

Add Reset

**If the TPL was denied, enter "0.00" in the Paid Amount field.**

**If the TPL was denied, enter the denial date in the Paid Date field.**

**If the TPL was denied, enter "1" in the Paid Units field.**

# Institutional Claim with TPL

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields.

Check the "Include Other Insurance" box under the Claim Information section, then click "Continue."

**Submit Institutional Claim: Step 1**

**Claim Information**

\*Covered Dates 04/23/2018 - \*04/25/2018

\*Admission Date/Hour 04/23/2018 (hh:mm) Discharge Hour (hh:mm)

\*Admission Type 3-Elective \*Admission Source 2-Clinic or Physician's Office

\*Admitting Diagnosis Type ICD-10-CM \*Admitting Diagnosis F03-UNSPECIFIED DEMENTIA

\*Patient Status 01-Discharged to Home or \*Facility Type Code 86-Residential Facility

\*Patient Number test1234

Previous Claim ICN

**Include Other Insurance**  Total Charged Amount \$0.00

**Continue** **Cancel**

**2. On the Submit Institutional Claim: Step 2 page under the Other Insurance Details section, enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select Other Carrier and type the Carrier Name.**

**Submit Institutional Claim: Step 2**
?

**Other Insurance Details**
-

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

Refresh Other Insurance

#	Carrier	Policy ID	Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.					
<div style="border: 2px solid red; padding: 5px;">                     Select an existing Carrier or specify an Other Carrier                     <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 5px;"> <div style="width: 60%;"> <input checked="" type="radio"/> Existing Carrier <input style="width: 150px;" type="text"/> </div> <div style="width: 35%;"> <input type="radio"/> Other Carrier <input style="width: 100px;" type="text"/> </div> </div> </div>					

**3. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates.**

**Other Insurance Details**
-

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

Refresh Other Insurance

#	Carrier	Policy ID	Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.					
<div style="border: 2px solid red; padding: 5px;">                     Select an existing Carrier or specify an Other Carrier                     <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 5px;"> <div style="width: 60%;"> <input checked="" type="radio"/> Existing Carrier <input style="width: 150px;" type="text"/> </div> <div style="width: 35%;"> <input type="radio"/> Other Carrier <input style="width: 100px;" type="text"/> </div> </div> <div style="margin-top: 10px; display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>*Policy Holder Last Name</b> <input style="width: 150px;" type="text"/></p> <p><b>*Policy ID</b> <input style="width: 150px;" type="text"/></p> <p><b>*Effective From</b> <input style="width: 100px;" type="text"/> <input style="width: 20px;" type="text"/></p> </div> <div style="width: 45%;"> <p><b>*First Name</b> <input style="width: 150px;" type="text"/> <b>MI</b> <input style="width: 20px;" type="text"/></p> <p><b>Effective To</b> <input style="width: 100px;" type="text"/> <input style="width: 20px;" type="text"/></p> </div> </div> </div>					

**4. Proceed to the Submit Institutional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added. Once complete, click "Submit."**

**Submit Institutional Claim: Step 3** ?

**Service Details** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
<u>1</u>							

1 **\*Revenue Code**  **HCPCS/Proc Code**

**Modifiers**

**From Date**   **To Date**   **\*Units**  **\*Unit Type**

**\*Charge Amount**

**Add**
**Reset**

**Attachments** -

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
<input style="width: 100%; height: 20px;" type="text" value="Click to add attachment."/>					

**Back to Step 1**
**Back to Step 2**
**Submit**
**Cancel**

# Entering Medicare Crossover Information on a Claim

## Professional Claim with Medicare (Crossover)

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields under the Provider Information, Member Information and Claim Information sections. Do **not** check the "Include Other Insurance" box under the Claim Information section. Click "Continue."

**Submit Professional Claim: Step 1**

**Provider Information**

Billing Provider ID  ID Type  Name   
Taxonomy

Referring Provider ID  ID Type  Name   
Taxonomy

Supervising Provider ID  ID Type  Name   
Taxonomy

Service Facility Location ID  ID Type  Name   
Taxonomy

**Member Information**

\*Member ID

Last Name  First Name   
Birth Date

Address

City   
State  Zip Code

**Claim Information**

Date Type  Date of Current

Accident Related Reason

\*Patient Number

\*Transport Certification  Yes  No

Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.

Previous Claim ICN

Note

\*Does the provider have a signature on file?  Yes  No

Include Other Insurance

Total Charged Amount \$0.00

**Do not check the "Include Other Insurance" box.**

**Continue** **Cancel**

**2. On the Submit Professional Claim: Step 2 page, complete all applicable fields under the Diagnosis Codes section, then click "Add." Repeat until all diagnosis codes have been added, then click "Continue."**

Submit Professional Claim: Step 2			
Diagnosis Codes			
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.			
#	Diagnosis Type	Diagnosis Code	Action
<u>1</u>			
1	*Diagnosis Type <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>			
<input type="button" value="Back to Step 1"/>		<input type="button" value="Continue"/> <input type="button" value="Cancel"/>	

**3. On the Submit Professional Claim: Step 3 page under the Medicare Crossover Details section, enter the associated Medicare crossover information for each service line. Click "Add" to repeat the process until all service detail lines have been added. Once complete, click "Submit."**

**Submit Professional Claim: Step 3**

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 \*From Date  To Date  \*Place of Service  EMG

\*Procedure Code  Modifiers  \*Diagnosis Pointers

\*Charge Amount  \*Units  \*Unit Type  EPSDT Service  Family Plan Service

CLIA Number

Rendering Provider ID  ID Type

Taxonomy

Referring Provider ID  ID Type

Taxonomy

**Medicare Crossover Details**

Allowed Medicare Amount  Co-insurance Amount

Deductible Amount  Psychiatric Services Amount

Medicare Payment Amount  \*Medicare Payment Date

**Attachments**

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

**Medicare HMO Copays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-insurance Amount" field.**

## Institutional Inpatient Claim with Medicare (Crossover)

1. On the **Submit Institutional Claim: Step 1** page, complete all applicable fields under the **Provider Information** and **Member Information** sections.

**Submit Institutional Claim: Step 1**
?

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

<b>Billing Provider ID</b>	<input type="text"/>	<b>ID Type</b>	<input type="text"/>	<b>Name</b> _
	<input type="text"/>		<input type="text"/>	
	<b>Taxonomy</b> <input type="text"/>			
<b>Institutional Provider ID</b>	<input type="text"/>	<b>ID Type</b>	<input type="text"/>	<b>Name</b> _
	<input type="text"/>		<input type="text"/>	
	<b>Taxonomy</b> <input type="text"/>			
<b>Attending Provider ID</b>	<input type="text"/>	<b>ID Type</b>	<input type="text"/>	<b>Name</b> _
	<input type="text"/>		<input type="text"/>	
	<b>Taxonomy</b> <input type="text"/>			
<b>Operating Provider ID</b>	<input type="text"/>	<b>ID Type</b>	<input type="text"/>	<b>Name</b> _
	<input type="text"/>		<input type="text"/>	
	<b>Taxonomy</b> <input type="text"/>			
<b>Other Operating Provider ID</b>	<input type="text"/>	<b>ID Type</b>	<input type="text"/>	<b>Name</b> _
<b>ID</b>	<input type="text"/>		<input type="text"/>	
	<b>Taxonomy</b> <input type="text"/>			

**Member Information**

<b>*Member ID</b> <input type="text"/>	<b>First Name</b> _
<b>Last Name</b> _	
<b>Birth Date</b> _	
<b>Address</b> <input type="text"/>	
<input type="text"/>	
<b>City</b> <input type="text"/>	
<b>State</b> <input type="text"/>	<b>Zip Code</b> <input type="text"/>

2. Proceed to the Claim Information section and complete all applicable fields. Select the appropriate Facility Type Code from the drop-down list. Do **not** check the "Include Other Insurance" box under the Claim Information section.

The screenshot shows the 'Claim Information' section of a web form. A dropdown menu is open, showing facility type codes: 11-Hospital Inpatient (Part A), 18-Hospital Swing Bed, 21-SNF Inpatient, 28-SNF Swing Bed, 41-Religious Nonmedical Health Care Institutions - Inpatient, 65-Intermediate Care - Level I, 66-Intermediate Care - Level II, and 86-Residential Facility. A red box highlights the '\*Facility Type Code' dropdown menu. A red arrow points from a yellow callout box to the '\*Include Other Insurance' checkbox, which is currently unchecked. Other fields include '\*Covered Dates', '\*Admission Date/Hour', '\*Admission Type', '\*Admission Source', '\*Admitting Diagnosis Type', '\*Admitting Diagnosis', '\*Patient Status', and '\*Patient Number'. A note at the bottom says 'Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.' The 'Total Charged Amount' is \$0.00.

**Do not check the "Include Other Insurance" box.**

3. Proceed to the Medicare Crossover Details section and complete all applicable fields, then click Continue."

The screenshot shows the 'Medicare Crossover Details' section. Fields include 'Deductible Amount' (0.00), 'Blood Deductible Amount' (0.00), 'Medicare Payment Amount' (0.00), 'Co-insurance Amount' (0.00), and '\*Medicare Payment Date'. A red arrow points from a yellow callout box to the 'Co-insurance Amount' field. A red box highlights the 'Continue' button. A 'Cancel' button is also visible.

**Medicare HMO Copays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-insurance Amount" field.**



# Institutional Outpatient Claim with Medicare (example for Part B-only)

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields. Do **not** check the "Include Other Insurance" box under the Claim Information section. Once complete, click "Continue."

**When billing Medicare Part B-only (for inpatient services on an outpatient claim), choose facility type 12 from the drop-down list.**

- 12-Outpatient
- 13-Hospital Outpatient
- 14-Hospital Other Part B
- 22-SNF Inpatient Part B
- 23-SNF Outpatient
- 32-Home Health
- 34-Home Health (Part B Only)
- 43-Religious Nonmedical Health Care Institutions - Outpatient
- 71-Clinical Rural Health
- 72-Clinic ESRD
- 73-Federally Qualified Health Centers
- 74-Clinic OPT
- 75-Clinic CORF
- 76-Community Mental Health Centers
- 77-Clinic - FQHC
- 78-Licensed Freestanding Emergency Medical Facility
- 79-Clinic - Other
- 81-Nonhospital based hospice
- 82-Hospital based hospice

**Submit Institutional Claim: Step 1**

**Claim Information**

\*Covered Dates 04/23/2018 - \* 04/25/2018

Admission Date/Hour 04/23/2018 (hh:mm) Discharge Hour (hh:mm)

Admission Type 3- Elective Admission Source 1

Admitting Diagnosis Type ICD-10-CM Admitting Diagnosis

Patient Status \*Facility Type Code 13-Hospital Outpatient

\*Patient Number test1234

Previous Claim ICN

Note

Include Other Insurance  Total Charged Amount \$0.00

**Continue** **Cancel**

**Do not check the "Include Other Insurance" box.**

**2. On the Submit Institutional Claim: Step 2 page, complete all applicable fields, then click "Add." Repeat the process as needed for each detail line. Once complete, click "Continue."**

**Submit Institutional Claim: Step 2** ?

**Diagnosis Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1			
1	*Diagnosis Type ICD-10-CM	*Diagnosis Code	
<b>Add</b> <b>Reset</b>			

**External Cause of Injury Diagnosis Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Diagnosis Type	External Cause of Injury Diagnosis Code	Action
1			
1	*Diagnosis Type ICD-10-CM	*External Cause of Injury Diagnosis Code	
<b>Add</b> <b>Reset</b>			

**Patient Reason for Visit Diagnosis Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Diagnosis Type	Patient Reason for Visit Diagnosis Code	Action
1			
1	*Diagnosis Type ICD-10-CM	*Patient Reason for Visit Diagnosis Code	
<b>Add</b> <b>Reset</b>			

**Condition Codes** -

Click the **Remove** link to remove the entire row.

#	Condition Code	Action
1		
1	*Condition Code	
<b>Add</b> <b>Reset</b>		

**Occurrence Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
For an Occurrence Code enter the same From and To Date. For an Occurrence Span enter the From and To dates of the span.

#	Occurrence Code	From Date	To Date	Action
1		-	-	
1	*Occurrence Code	*From Date	*To Date	
<b>Add</b> <b>Reset</b>				

**Value Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Value Code	Amount	Action
1			
1	*Value Code	*Amount	
<b>Add</b> <b>Reset</b>			

**Surgical Procedures** -

Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this panel.

**Back to Step 1** **Continue** **Cancel**

**3. On the Submit Institutional Claim: Step 3 page, complete all applicable fields under the Service Details section. Enter the associated Medicare Crossover Details for each service line. Click "Add" to repeat the process until all service detail lines have been added. Click "Submit" once completed.**

**Submit Institutional Claim: Step 3** ?

**Service Details** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
<u>1</u>							

1 **\*Revenue Code**  **HCPCS/Proc Code**

**Modifiers**

**From Date**   **To Date**   **\*Units**  **\*Unit Type**

**\*Charge Amount**

**Medicare Crossover Details**

**Deductible Amount**  **Co-insurance Amount**

**Blood Deductible Amount**

**Medicare Payment Amount**  **\*Medicare Payment Date**

**NDCs for Svc. # 1** +

**Medicare HMO Copays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-insurance Amount" field.**

## **Need More Help?**

Please visit the [Quick Guides and Webinars](#) web page to find all the Provider Web Portal Quick Guides.